THE DERMATOLOGY CLINIC

Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: _____

I authorize the custodian of records of: _____
to disclose/release the following information* (check all applicable):

☐ All records ☐ Laboratory/pathology records ☐ X-ray/radiology records

☐ Billing records ☐ Abstract/Summary ☐ Pharmacy/prescription records

☐ Other (describe specifically): _____

*_**Note**_: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

These records are for services provided on the following date(s): _____

Please send the records listed above to:

Name of Facility/Organization: _____

Street Address: _____

City: _____

State: _____ Zip: _____

Phone: _____ Fax: _____

_____ _____
Signature of patient (or patient's personal representative) Date

_____ _____
Printed name of patient representative Representative's authority to sign for patient, (i.e. parent, guardian, power of attorney for healthcare)

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